Certified Application Assistance Site (CAAS)
Application

In completing this application, you are applying to become a site where families may receive Colorado Public Health Insurance for Families (Family Medicaid and CHP+) application assistance. Your organization will verify that you saw original or certified citizenship and identification documents.

If your agency has multiple locations, please complete a form for each location.

Agency Name: _____

Agency Address (street, city, zip): _____

Contact Name:_____**Contact email address:**_____

Telephone #: _____ **County:**_____

Agency Address where community can receive assistance (if different than above - street, city, zip): _____

Telephone # community can contact with questions:_____

Please read and check all of the following that apply:

☐ Our agency agrees to adhere to all rules, regulations and agency letters as set forth by the Department of Health Care Policy and Financing (Department).

☐ Our agency agrees to ensure that all staff assisting with clients are adequately trained on the process for completing an application and the proper procedure for verifying original citizenship and identity documents.

☐ Our agency understands that we are only liable if false documents are knowingly verified, in this case, our certification will be revoked.

☐ Our agency will read the CAAS training on the Colorado.gov/hcpf Web Site and/or appropriate designated trainers.

☐ Our agency agrees to submit completed applications and all documentation to the client's county of residence or CHP+ within five business days.

☐ Our agency is a non-profit organization or other community-based group and we understand that we are supporting community and not an individual's interest.

☐ Our agency agrees to have our location posted on the Department Web site. This means we will assist ALL clients that come to our organization for application assistance.

☐ Agency agrees to abide by all applicable HIPAA Privacy and Security requirements regarding health information as defined in 42 U.S.C. 1320d – 1320d-8, and implementing regulations at 45 C.F.R. Parts 160, 162 and 164.

☐ Our agency agrees to inform the Department within 45 days when our agency withdraws from the CAAS Program.

☐ Our agency understands that the Department may choose to revoke our certification at any time.

☐ Our agency agrees to offer voter registration, pursuant to the National Voter Registration Act of 1993, 42 U.S.C.S 1973gg-5(a)(2)(H) at the time of application and will be required to track the number of voter registrations offered.

Authorized Signature:

_____

Please submit this form to: Department of Health Care Policy and Financing
Attn: Tonya Bruno 1570 Grant Street Denver, CO 80203
Fax: 303-866-2505

DEPARTMENT USE ONLY

Approval By: _____ Approval Date: _____ Certification # Assigned: _____